



**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

APPEAL DECISION SUMMARY

APPEAL No: 2011-1694

DATE: September 7, 2011

AGENCY: DSS

OUTCOME: (check one)

☐ SUSTAINED ☐ REVERSED ☒ REMANDED
☐ INVALID/FULL
☐ SUSTAINED and REMANDED
☐ REVERSED and REMANDED
☐ AGENCY ERROR/OTHER

ISSUE ON APPEAL: Eligibility-ABD-excess resources

GENERAL RULE OF LAW: Requirement to meet resource guidelines

1. 42 U.S.C. § 1396a(a)(17)(B) requires a state plan for medical assistance to include:

- i. reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . (B) provide for taking into account only such income and resources as are . . . available to the applicant or recipient.

2. The Medicaid eligibility determination consists of an evaluation that compares each of an individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all possible covered groups and categories and the applicant/recipient shall be informed of all known facts that affect eligibility. Medicaid Manual, Volume XIII, M0210.001, A (p. 1).

3. In order to be eligible for Medicaid, in addition to meeting non-financial requirements, an individual must meet all the requirements of a Medicaid covered group. There are two classifications of covered groups, the categorically needy (CN) and the medically needy (MN). The CN classification is divided into subclassifications of categorically needy, categorically needy non-money payment (CNNMP) and medically indigent (MI). Within some covered groups are several definitions of eligible individuals. The agency must verify that an individual meets a definition and a covered group's requirements in order

for that individual to be eligible for Medicaid. Medicaid Manual, Volume XIII, M0310.001, A (p. 1).

4. There are non-financial and financial eligibility requirements that must be met before an individual can be determined eligible for Medicaid. The financial eligibility requirements include an evaluation of asset transfers, resources and income. Asset transfers may affect eligibility for institutionalized individuals. Resources and income must be within the resource and income limits appropriate to the individual's covered group. Medicaid Manual, Volume XIII, M0210.001, B, 1 & 2 (p. 1).
5. The Aged, Blind, and Disabled (ABD) covered groups in the CNNMP subclassification include ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit. Medicaid Manual, Volume XIII, M0310.002, B, 1 (p. 2).
6. The ABD covered groups in the MN classification include:
 - a. Aged – age 65 years or older
 - b. Blind – meets the blind definition;
 - c. Disabled – meets the disability definition
 - d. Certain other individuals who received Medicaid in December, 1973 and continue to meet the December, 1973 eligibility requirements.

Medicaid Manual, Volume XIII, M0310.002, D, 1 (p. 4).

7. The MI ABD covered groups include:
 - a. Qualified Medicare Beneficiaries (QMB's)
 - b. Special Low-income Medicare Beneficiaries (SLMB's)
 - c. Qualified Disabled and Working Individuals (QDWI's)
 - d. Qualified Individuals – (QI's)
 - e. ABD with Income less than 80% Federal Poverty Level (ABD 80% FPL).

Medicaid Manual, Volume XIII, M0310.002, C, 1 (p. 3).

8. QMB's, SLMB's, and QI's, and QDWI's must be entitled to or receiving Medicare Part A hospital insurance benefits and must also meet financial eligibility requirements. Medicaid Manual, Volume XIII, M0320.206, B, 1 (p. 34); M0320.207, B, 1 (p. 38); M0320.208, B, 2 (p. 42a); M0320.209, B (p. 42e).
9. As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income. Medicaid Manual, Volume XIII, M1110.001, A (p. 1).

10. Resources are cash and any other personal or real property that an individual (or spouse, if any) owns; has the right, authority, or power to convert to cash (if not already cash); and is not legally restricted from using for his/her support and maintenance. Medicaid Manual, Volume XIII, S1110.100, B, 1 (p. 3).
11. Resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law. An individual with countable resources in excess of the applicable limit is not eligible for Medicaid. Medicaid Manual, Volume XIII, M1110.003, A (p. 2); M1110.003, B, 1 (p. 2).
12. The income and resource limits are established in relation to the number of persons in the assistance unit. The number of persons in the assistance unit and the individual's covered group classification determine which resource and income limits apply. Medicaid Manual, Volume XIII, M0510.001, A (p. 1)
13. An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of "institutionalization." Medicaid Manual, Volume XIII, M1460.300, A (p. 12).
14. An unmarried ABD individual's assistance unit consists of one person--the individual. The individual's child(ren) living with him or her are NOT included in the ABD individual's assistance unit, nor is any of the individual's resources or income allocated for the child(ren) when determining countable resources and countable income. Medicaid Manual, Volume XIII, M0530.100, A, B (p. 13).
15. The resource limit for one person in the CN, CNNMP, and MN covered groups is \$2,000. The resource limit for one person in the MI ABD with income \leq 80% Federal Poverty Limit (FPL) covered group is \$2,000. The resource limit for one person in the QMB, SLMB, and QI covered groups is \$6,680. Medicaid Manual, Volume XIII, M1110.003, B, 2 (p. 2).
16. Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. Medicaid Manual, Volume XIII, M1110.600, A (p. 18).
17. The eligibility worker must verify the value of all countable, non-excluded resources. Medicaid Manual, Volume XIII, M0130.200, H (p. 8).
18. A life insurance policy owned by the individual is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV. Medicaid Manual, Volume XIII, M1130.300, B, 1 (p. 20).
19. Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. A life insurance policy is an excluded resource, for individuals age 21 and over, if it's FV and the FV of any other life insurance policies the individual owns on the

same insured total \$1,500 or less. Burial insurance policies and term insurance policies that do not generate a CSV are not taken into account. Medicaid Manual, Volume XIII, M1130.300, A, 2 (p. 18); M1130.300, B, 2 & 3 (p. 20).

20. The maximum of \$3,500 can be excluded from countable resources if the funds are set aside for:
- the burial expenses of the individual; and
 - the burial expenses of the individual's spouse

Medicaid Manual, Volume XIII, M1130.410, C, 1 (p. 28).

21. A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value. Medicaid Manual, Volume XIII, M1130.400, A (p. 24).
22. The countable value of a bank account is the lower of the balance before income is added, or the ending balance minus any income added during the month. Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. Medicaid Manual, Volume XIII, M1140.200, B, 5 (p. 18).
23. The retroactive period is the three months immediately prior to the application month. Medicaid Manual, Volume XIII, M1510.101, A, 1 (p. 2).
24. An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application. Medicaid Manual, Volume XIII, M1510.101, B (p. 2).

AGENCY DECISION: The Hearing Officer remanded the case to the agency for further evaluation based upon the following:

The local agency verified the Appellant's resources and correctly determined that the Appellant's total countable resources exceeded the limit for the full coverage Medicaid groups. The agency failed to evaluate the Appellant for retroactive coverage and eligibility for the limited Medicaid covered groups; therefore, the case was remanded.

APPLICABLE LAW/REGULATIONS/POLICY

United States Code

42 U.S.C. §1396a(a)(17)(B)

Medicaid Manual, Volume XIII

M0130.100, B, 2 (p. 2)
M0130.200, H (p. 8)
M0210.001, A (p. 1)
M0210.001, B, 1 & 2 (p. 1)
M0310.001, A (p. 1)
M0310.002, D, 1 (p. 4)
M0310.002, C, 1 (p. 3)
M0310.002, B, 1 (p. 2)
M0320.206, B, 1 (p. 34)
M0320.207, B, 1 (p. 38)
M0320.208, B, 2 (p. 42a)
M0320.209, B (p. 42e)
M0510.001, A (p. 1)
M0530.100, A & B (p. 13)
M1110.001, A (p. 1)
M1110.003, A (p. 2)
M1110.003, B, 1 & 2 (p. 2)
S1110.100, B, 1 (p. 3)
M1110.600, A (p. 18)
M1130.300, B, 1 (p. 20)
M1130.300, A, 2 (p.18)
M1130.300, B, 2 & 3 (p. 20)
M1130.400, A (p. 24)
M1130.410, C, 1 (p. 28)
M1140.200, B, 5 (p. 18)
M1140.200, B, 6, b (p. 18)
M1460.300, A (p. 12)
M1510.101, A, 1 (p. 2)
M1510.101, B (p. 2)
M1510.102, C (p. 8)